1st DAC

PTO/SB/61 (01-08)
Approved for use through 06/30/2008. OMB 0651-0031
U.S. Patent and Trademark Office; U.S. DEPARTMENT OF COMMERCE

PETITION FOR REVIVAL OF AN APPLICATION FOR PATENT ABANDONED UNAVOIDABLY UNDER 37 CFR 1.137(a)	Docket Number (Optional)

First Named Inventor: WILLIAM BONIFACIO
Art Unit: 3746
Application Number: 10/804,370
Examiner: VIKANSHA S. DWIVEDI
Filed:

Title: A WATER POWERED PUMP FOR REMOVING SUMP PIT WATER.

Attention: Office of Petitions
Mail Stop Petition
Commissioner for Patents
P.O. Box 1450
Alexandria, VA 22313-1450

NOTE: If information or assistance is needed in completing this form, please contact Petitions Information at (571) 272-3282.

The above-identified application became abandoned for failure to file a timely and proper reply to a notice or action by the United States Patent and Trademark Office. The date of abandonment is the day after the expiration date of the period set for reply in the Office notice or action plus any extensions of time actually obtained.

APPLICANT HEREBY PETITIONS FOR REVIVAL OF THIS APPLICATION.

NOTE: A grantable petition requires the following items:
(1) Petition fee.
(2) Reply and/or issue fee.
(3) Terminal disclaimer with disclaimer fee – required for all utility and plant applications filed before June 8, 1995, and for all design applications; and
(4) Adequate showing of the cause of unavoidable delay.

1. Petition fee

☒ Small entity – fee $ 255.00 (37 CFR 1.17(l)). Applicant claims small entity status. See 37 CFR 1.27.

☐ Other than small entity – fee $_____ (37 CFR 1.17(l)).

2. Reply and/or fee

A The reply and/or fee to the above-noted Office action in the form of _____ (identify the type of reply):

☐ has been filed previously on _____.

☐ is enclosed herewith.

B The issue fee of $ _____

☐ has been filed previously on _____

☐ is enclosed herewith.

07/22/2008 EFLORES 00000031 10804370
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3. Terminal disclaimer with disclaimer fee

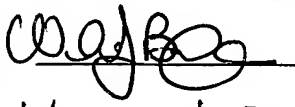
☐ Since this utility/plant application was filed on or after June 8, 1995, no terminal disclaimer is required.

☐ A terminal disclaimer (and disclaimer fee (37 CFR 1.20(d)) of $ _____ for a small entity or $ _____ for other than a small entity) disclaiming the required period of time is enclosed herewith (see PTO/SB/63).

4. An adequate showing of the cause of the delay, and that the entire delay in filing the required reply from the due date for the reply until the filing of a grantable petition under 37 CFR 1.137(a) was unavoidable, is enclosed.

WARNING:

Petitioner/applicant is cautioned to avoid submitting personal information in documents filed in a patent application that may contribute to identity theft. Personal information such as social security numbers, bank account numbers, or credit card numbers (other than a check or credit card authorization form PTO-2038 submitted for payment purposes) is never required by the USPTO to support a petition or an application. If this type of personal information is included in documents submitted to the USPTO, petitioners/applicants should consider redacting such personal information from the documents before submitting them to the USPTO. Petitioner/applicant is advised that the record of a patent application is available to the public after publication of the application (unless a non-publication request in compliance with 37 CFR 1.213(a) is made in the application) or issuance of a patent. Furthermore, the record from an abandoned application may also be available to the public if the application is referenced in a published application or an issued patent (see 37 CFR 1.14). Checks and credit card authorization forms PTO-2038 submitted for payment purposes are not retained in the application file and therefore are not publicly available.



Signature

6/25/08
Date

WILLIAM J. BONIFACIO JAMES D. BELLE
Typed or printed name

Registration Number, if applicable

107 WICKHAM DRIVE
Address

716-873-0081
Telephone Number

WILLIAMSVILLE, NY 14221
Address

Enclosure ☒ Fee Payment

☐ Reply

☐ Terminal Disclaimer Form

☐ Additional sheets containing statements establishing unavoidable delay

☐ _____

CERTIFICATE OF MAILING OR TRANSMISSION (37 CFR 1.8(a))

I hereby certify that this correspondence is being:

☒ deposited with the United States Postal Service on the date shown below with sufficient postage as first class mail in an envelope addressed to **Mail Stop Petition**, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450.

☐ transmitted by facsimile on the date shown below to the United States Patent and Trademark Office at (571) 273-8300.

6/24/08
Date

Signature

WILLIAM J. BONIFACIO
Typed or printed name of person signing certificate

PTO/SB/61 (01-08)
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NOTE: The following showing of the cause of unavoidable delay must be signed by all applicants or by any other party who is presenting statements concerning the cause of delay.

_____	6/25/08
Signature	Date
James D. Belue	_____
Typed or printed name	Registration Number, if applicable

(In the space provided below, please explain in detail the reasons for the delay in filing a proper reply.)

SEE ATTACHED SHEETS

(Please attach additional sheets if additional space is needed.)

DATED: 6/24/08

Re: Unavoidable delay in response.

In August, 2007 we received an Office Action Summary indicating that our original application needed some clarification. In September and October, we began working on the necessary revisions with respect to the specifications, drawings, and claims. As November approached, James Belle, the lead applicant who was integral to its re-work, began to demonstrate increased symptoms of his already existing medical condition, Lupus. It eventually led to a reduction in his ability to perform his duties on this project and eventually led to kidney failure and a need for dialysis. In December, 2007 preparations were made to begin medical treatment. Surgery was performed in early January and dialysis began shortly after that. Immediately, Mr. Belle experienced strong negative reactions to his treatments including two ambulance trips, three hospital stays for seizures, high fevers, extreme fatigue, high blood pressure, and other symptoms which are all documented (see attached). Increased medications to counteract these conditions also led to reactions of their own. Further surgery was required in February. Slowly he returned to work on a limited basis and began again to contribute to the patent process, when we received the notice of abandonment. Mr. Belle continues to be on dialysis, which reduces his energy and time available to devote to finalizing the patent process, but he is doing his best to contribute to the completion of the project. While Mr. Belle was experiencing this, Mr. Bonifacio, the other applicant, was unable to continue on the project without Mr. Belle's input. We are attaching supporting documents with respect to the above mentioned medical condition.

ECMCC

ERIE COUNTY MEDICAL CENTER CORPORATION

[redacted]

#3263266

DANGER SIGNALS TO WATCH FOR. CALL YOUR DOCTOR IF YOU HAVE QUESTIONS/CONCERNS :

- ☑ Temperature over 101° for a day
- ☐ More or new swelling at your operative site
- ☑ Other Altered Mental Status
- ☐ More or unrelieved pain
- ☐ Redness, drainage or warmth at the site
- ☑ Other Seizure

TREATMENT : Location BGH

EQUIPMENT/OXYGEN : X

DISCHARGE DIET ☐ No restrictions ☑ Special instructions : Renal diet

ACTIVITY : You may ☑ Resume activity as tolerated ☐ NO strenuous activity

Return to work/school ☐ May not ☐ May on _____

☐ Activity as described in Head Injury Instruction Sheet

☐ Shower ☐ Climb stairs ☐ Drive a car ☐ Lift with no limit ☐ Weight bear

☐ Tub bath ☐ Exercise ☐ Resume sexual activities ☐ Lift : limit to _____ lbs

FOLLOW UP : Physician appointment/Laboratory Work/Test

Call to make an appointment | **An appointment has been made for you**

F/u for dialysis T, T, S

F/u with Dr. Cunningham (Nephrologist)

HOME CARE AGENCY _____ **TO CALL DR** _____

FOR _____

RN may discontinue ☐ Telemetry ☑ IV access ☐ Pulse Oximetry ☐ Other

☐ **Patient currently has or has a past history of CHF &/or fluid overload. Provide CHF Booklet to patient**

Physician/Nurse Practitioner/Physician Assistant Signature

K HALIP MD.
Stamper

01/11/08
Date

DISCHARGE PLAN

Discharge date _____ **time** _____ **By :** ☐ W/C ☐ Ambulance ☐ Other _____

Transportation Provider _____ Scheduled pick-up time _____

Services ☐ None **Services arranged** ☐ Home Care ☐ Other

Equipment ☐ None **Delivered to** ☐ Hospital prior to discharge ☐ Home ☐ Scripts given patient will obtain

Provider _____ Phone Number _____

Provider _____ Phone Number _____

Other _____ Phone Number _____

Discharge Planner's signature _____ Date _____

☐ Patient/rep received these instructions & verbalized understanding

☐ Patient/representative refused instructions

Registered Nurse's Signature _____

☐ I received & understand these instructions and the discharge notice. These were reviewed to my satisfaction.

Patient/Representative Signature _____

ECMC FORM # 0622470 Revised 1/07

Original to chart; yellow copy to patient; pink copy to Case Manager/facility

HOW TO STOP SMOKING

hy should I quit smoking cigarettes?

ıe number one reason to quit smoking is that it reduces your risks of dying. Death from smoking is eventable. As a smoker you are higher risk than a non-smoker of having heart problems and many pes of cancers including cancers of the lip, mouth & pharynx, esophagus, pancreas, lung, cervix, ladder, and kidney. You are more likely to develop respiratory tract infections (colds, sinus infections nd pneumonia), and life-long breathing problems such as chronic bronchitis and emphysema. You re at higher risk for developing ulcers, cataracts, and osteoporosis, as well as having medical roblems or dying after surgery. Cigarettes are expensive and smokers have higher medical costs ver their lifetime than non-smokers. Lastly, second hand smoke increases the risk of illness to your oved ones.

Who will support me as I try to quit using nicotine?

Ask your caregiver for help. Ways have been found to help people quit smoking including counseling (talk therapy), behavior change therapy, and hypnosis. Frequent one-to-one group and telephone discussions are helpful if you are trying to quit smoking or using nicotine in any form. Support and encouragement from others and learning ways to deal with stress are very important. There are also products such as gum, inhalers, patches, and certain medicines that your caregiver may suggest. Do not use any products that claim to be able to help you stop smoking without talking to your caregiver first.

Where can I go for support?

National Network of Tobacco Cessation Quit lines
Phone : 1-800-QUIT NOW.

American Heart Association National Center
7272 Greenville Avenue Dallas, TX 75231-4596
Phone : 1-800-242-8721

American Cancer Society
1599 Clifton Road NE Atlanta, GA 30329
Phone : 1-800-227-2345.
Web Address: http://www.cancer.org

American Lung Association
1740 Broadway New York, NY 10019-4374
Phone : 1-800-586-4872
Web Address: http://www.lungusa.org

New York State Smokers' Quit line sponsored by Roswell Park Cancer Institute
Elm and Carlton Streets
Buffalo, New York 14263
1-866-NY-QUITS (1-866-697-8487) or 1-866-QUIT-FAX
www.nysmokefree.com

What can I do to avoid going back to using nicotine?

- Avoid old activities that trigger the urge to smoke. Try new activities.
- Keep your list of reasons why you want to quit handy and review it often.
- Talk to your friends and family every day. Ask them to support your effort to quit smoking.
- Do things with your hands such as knitting, writing letters, doing crossword puzzles, gardening or washing the car.
- Keep cigarette substitutes around such as carrot or celery sticks, sunflower seeds, apples, raisins, sugarless gum or candy. Use them as needed.
- Mark every successful day on your calendar.
- Reward yourself every day or week. It will keep you positive and feeling successful. Choose healthy rewards such as taking a long bath or tying a new exercise or craft class.
- Start saving the money that you would have spent on nicotine products. Spend the money on a gift for yourself or someone special.
- If you do smoke a cigarette or use a nicotine product, do not give up. Stop and think of how many hours, days, or weeks you have already managed to get through. Try to identify what caused you to smoke and add it to your list of things to avoid. If you can't avoid the trigger, practice how you will deal with it next time. Review all of the health risks that come with using nicotine, to both yourself and others. Review all the reasons why you stopped using nicotine.

DO YOU HAVE HEART DISEASE? HOW TO MANAGE YOUR HEART FAILURE :

CHF: Congestive Heart Failure (or Heart Failure) is when your heart is not pumping blood [illegible] because your heart muscle may be weak or damaged. Your heart has to work [illegible] amount of blood your body needs for everyday activities.

What causes heart failure :

- Weakness of the heart muscle cause by a heart attack, an infection, or excessive alcohol intake
- High blood pressure causing the heart to work harder to pump blood out to the body
- Problems with heart valves
- Irregular heart beat

Signs of heart failure :

- Shortness of breath with activity or when lying flat
- Dry, constant cough that may worsen at night
- Swelling of feet or legs. The swelling can extend up to the waist.
- Waking up at night coughing or breathless
- Tiredness or weakness
- Decrease in urination or frequently having to urinate during the night
- Weight gain - sudden gain of 2 - 3 pounds per day or more than 5 pounds in 5 days

Activity: See your doctor's instructions about activity on the front of this paper. Take rest breaks in-between activities. It is helpful to put your feet up while resting. Stop activity if you have pain, shortness of breath, or feel dizzy. Avoid exercising after eating or when it is hot/humid or you aren't feeling well.

Food and Drink: Choose items with low or no salt. Your doctor may limit your food or drink choices due to other health conditions. If you need help with your food and drink choices, you can call your doctor. You should follow a **LOW SALT** diet and any other restrictions as indicated by your doctor.

Weight: Weigh yourself everyday! It is best to weigh yourself in the morning before your have anything to eat or drink, on the same scale, and wearing the amount of clothing. Write your weight on your weight log sheet and bring it to your doctor visits. If you gain more than 2 pounds in one day or 5 pounds in one week, ***call*** your doctor.

Medications: There are five kinds of medications that may be used to treat your heart failure. These will improve the functioning of your heart because they help :

- Make your heart pump stronger by improving its strength (Digoxin or Lanoxin)
- Decrease the amount of extra fluid in your body (Diuretics, "water pills")
- Keep the minerals in your blood that your body needs to function (Potassium)
- Relax your blood vessels so your heart can work easier (ACE inhibitors or vasodilators)
- Protect your heart against dangerous heart rhythms and relax the heart (beta blockers)

Be sure to take ALL of your medications and at the CORRECT times

When do I need to see my Doctor?

- Weight gain of more than 3 pounds in one day, or 7 pounds in one week.
- Swollen ankles, legs or abdomen
- Increased fatigue
- Increased shortness of breath on exertion, shortness of breath at night or when lying flat
- Unexplained cough, or a "hacking" night cough
- Decrease in urination or frequently having to urinate during the night

Call **911 if you:**

- Faint or pass out
- Become extremely short of breath or are unable to talk due to breathlessness
- Have severe chest pain that is not helped by three nitroglycerin pills taken at 5-minute intervals
- Have a continuously rapid, racing heartbeat

Physician Discharge Order Form

[redacted]
PELLE, JAMES
V00002174033
547 Patient Name 1/1953
01/09/08

Discharge to Home.
Discharge Diagnosis ESRD, Uremic dys. equilum Syndrome.
Doctor in Charge of your care Dr. Hom.
Service Medical.

Please share this information with your private doctor and pharmacist.
These instructions are guidelines. Please call your doctor for any problems or questions.
In the event of any emergency, call 911 or go to the nearest Emergency Department.

ALLERGIES : Source/nature of reaction Demerol, Procardia, Meperidine.

THESE ARE YOUR HOME MEDICATIONS (Use extra sheet as needed)

RN to provide

Drug Brand & Generic Name /Amount/Route, Special Instructions, & How often	Script given	Take next dose at	Care notes Given
Zetia 10mg PO daily dyslipidemia	X1		
Metoprolol 100mg PO BID HTN.	X1		
Prednisone 5.0mg PO M/W/F Lupus	X1		
Prednisone 2.5mg PO Su/T/Th/Sa	X1		
Renagel 800mg PO TIDWM ESRD	X1		
Metoclopramide 10mg PO QID prn Nausea	NO.		
~~Aranesp 100mg q wk SQ q 2 weeks~~ error			
& on Epogen w dialysis. R.H.			

TAKE THESE MEDICATIONS WHEN YOU GET HOME THAT WERE ADDED BY YOUR DOCTOR

RN to complete

Drug Brand & Generic Name /Amount/Route, Special instructions, & How Often	Script given	Take next dose at	Care notes Given
~~Minoxidil~~ NONE.			

TAKING THESE MEDICATIONS YOU TOOK AT HOME BEFORE HOSPITALIZATION

Drug Brand & Generic Name /Amount	
1. ~~Minoxidil~~ Minoxidil.	2. ~~Lisinopril~~
3. HCTZ	4.
5. ~~Aranesp~~ Aranesp → on Epo	6. with dialysis

ORDERING PHYSICIAN : CHECK THE MEDICATION HISTORY & DISPOSITION ORDER FORM TO ENSURE ALL MEDICATIONS ARE ACCOUNTED FOR
Physician : Use additional sheets as needed to list all medications. ☐ *Check this box if a second sheet was used.*

☐ **Immunizations while in the hospital** ☒ None given during this stay

☐ Flu Vaccine	Date		☐ Sheet given	Date on VIS
☐ Pneumococcal Vaccine	Date		☐ Sheet given	Date on VIS
☐ Other	Date		☐ Sheet given	Date on VIS

Twin City Ambulance Corp.

365 FILLMORE AVE
TONAWANDA, NY 14150
(716) 743-0916

Patient Name: BELLE, JAMES

Run Number: 08-1854
Date of Call: 1/25/2008
Time of Call: 10:16
Caller:

JAMES BELLE
158 RUE MADELEINE
BUFFALO, NY 14221

From: Residence
To: Erie County Medical Center

Primary payor: Medicare [redacted]

Secondary payor: Independent Health (2nd) [redacted]

Description	Check #	Quantity	Unit Price	Payment Date	Amount
ALS Emergency Base Rate		1	$805.00		805.00
Mileage		10	$11.00		110.00
Payment-Insurance Check	120039619	1		02/18/2008	341.05
Payment-Insurance Check	00001903551	1		03/31/2008	42.63
Write-off per Management		1		04/07/2008	11.00

5/22/08
EFT

PLEASE PAY THIS AMOUNT 31.63

DETACH ALONG LINE AND RETURN STUB WITH YOUR PAYMENT. THANK YOU.

Patient Name: BELLE, JAMES

Run Number: 08-1854
Current Date: 4/8/2008

AMOUNT ENCLOSED: $

Due on: 05/08/2008

REMIT TO: Twin City Ambulance Corp.
365 FILLMORE AVE
TONAWANDA, NY 14150

Your insurance has paid their portion of these charges. The balance due is your responsibility. If you have supplemental insurance which covers this amount, please contact us immediately. Any questions should be directed to our Billing Office.

Twin City Ambulance Corp.

365 FILLMORE AVE
TONAWANDA, NY 14150
(716) 743-0916

Patient Name: BELLE, JAMES

Run Number: 08-614
Date of Call: 1/8/2008
Time of Call: 22:27
Caller:

JAMES BELLE
158 RUE MADELEINE
BUFFALO, NY 14221

From: 158 RUE MADELEINE
To: Erie County Medical Center

Primary payor: Medicare [redacted]

Secondary payor: Independent Health (2nd) [redacted]

Description	Check #	Quantity	Unit Price	Payment Date	Amount
ALS Emergency Base Rate		1	$805.00		805.00
Mileage		9	$11.00		99.00
Payment-Insurance Check	120033333	1		02/11/2008	227.91
Payment-Insurance Check	00001889055	1		03/17/2008	141.98

$50.00
pd 5/16/08
E 4416 39

PLEASE PAY THIS AMOUNT **50.00**

DETACH ALONG LINE AND RETURN STUB WITH YOUR PAYMENT. THANK YOU.

Patient Name: BELLE, JAMES

Run Number: 08-614
Current Date: 4/16/2008

AMOUNT ENCLOSED: $

Due on: 05/16/2008

REMIT TO: Twin City Ambulance Corp.
365 FILLMORE AVE
TONAWANDA, NY 14150

This balance is now 30 days past due and needs your attention. If you have questions about this balance or need to set up a payment plan, please contact our office immediately. Thank you!

The VAC @ ECMC
462 Grider St Rm 1285
Buffalo, NY 14215

898-3484 between 8AM and 4PM
Monday through Friday
Off Hours: 677-5500

VASCULAR ACCESS DISCHARGE ORDERS/ INSTRUCTIONS

Procedure Performed Thrombectomy & Shuntogram / ~~poss~~. plasty / ~~poss~~. draining vein stent in draining vein

Procedure Performed by Blesdoe MD

Resume Diet/Medications as before the procedure

Return to dialysis on your previously scheduled date and time unless otherwise Instructed usual time & place

Nephrologist Cunningham Dialysis Unit DSC

Activity: You can resume you usual activity:

Do not use your access arm to lift, pull or push

Do not sleep on your access arm or allow blood pressures or blood draws From your access arm

You should feel your access once a day. Call the VAC if you don't feel the "buzz"

If you have prolonged or profuse bleeding hold pressure at the site and Dial 911 or report to the nearest Emergency Room

If you have swelling or severe pain in your arm or hand or if your hand is Extremely cold; call the VAC

If you have green or yellow drainage or a fever greater than 101; call the VAC

Stents Placed:	Yes
Heparin/TpA Given:	Given x2
Procedure Findings/Diagnosis:	Shuntogram / Thrombectomy Plasty Draining Vein / Stent draining vein
F/U for suture removal @ The VAC	Friday 4/25/08 ~~SAME~~ 9AM
Follow up procedures:	Doppler @ 6 months
When can Access be used for hemodialysis	~~Will~~ Use T needle on AVS tomorrow & ~~&~~ 2 weeks.
Tip Stop removal:	7PM
Prescriptions:	Coumadin, Plavix, Lotab

Patient Signature

Nurse Signature

Date: 4/16/08 Physician/Midlevel Signature Susan C. Katzakis NP